PACES Station 2: HISTORY TAKING

Patient details: Mr John Davidson, a 25-year-old man
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Fever

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for seeing this normally fit and well patient whom I have not seen before. He complains of sweats and rigors, headache, sore throat and generalised myalgia. This started abruptly last night.

On examination, he is febrile (39.0°C), sweaty and tachycardic (105 beats per minute). I am concerned because he is mildly photophobic, although I am not convinced he has neck stiffness. There is no rash.

I am concerned that he may have meningitis and would value your opinion.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

NOT TO BE USED IN THE EXAM

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

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PACES Station 2: HISTORY TAKING

Your role:
Location:

History of presenting symptoms

Information to be volunteered at the start of the consultation
You went to see your family doctor this morning whom you have not seen before. You were well until last night when you became somewhat achey, shivery and tired. You had an early night but awoke this morning with a generalised headache, sore throat and aching all over, especially in your back.

Your family doctor mentioned that you might have meningitis and has referred you.

Information to be given *if asked*
You feel hot and sweaty yet at other times cannot keep warm, and have had some shaking episodes and drenching sweats.
You do not like bright lights which irritate your eyes and head.
You confirm that one or two people in the office have been off with a similar illness recently.

Background information

Past medical and surgical history
None relevant.

Other complaints
None.

Medication record

Current medications
None.

Relevant previous medications
None.

Allergies and adverse reactions
None known.

Personal history

Lifestyle
You are usually well and are an active gym member. You have never smoked but you do enjoy a couple of glasses of wine in the evening.

Social and personal circumstances
You are married; you do not have any children.

Occupational history

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You work in IT in the accounts department of a local business.

Travel history
You had a safari holiday 3 months ago in Tanzania. **If asked,** you did not take the malaria pills suggested.

Family history
Your parents are alive and well.

Patient's concerns, expectations and wishes
You feel dreadful and wish to be better and more comfortable. You are naturally very worried at the mention of possible meningitis by your family doctor.

You have some specific questions for the doctor at this consultation:

- Have I got meningitis?
- When will I get some antibiotics?
- What can you do to make me feel better now?

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PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). If the candidate appears to have finished early remind them how long is left at the station and enquire if there is anything else they would like to ask, or whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

Examiners should refer to the marking guidelines in the five skill domains on the marksheet.

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. The boxes on the next page indicate areas of potential interest in this case which both examiners should consider, along with any other areas they feel appropriate. Examiners must agree the issues that a candidate should address to achieve a Satisfactory award for each skill and record these on the calibration sheet provided. Examiners should also agree the criteria for an Unsatisfactory award at each skill.

NOT TO BE USED IN THE EXAM

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 11

Problem: Fever
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mr John Davidson, a 25-year-old man

Examiners are reminded the areas below indicate areas of potential interest, but are not intended as absolute determiners of Satisfactory performance. It is for the examiners to agree and record the specific criteria they will assess the candidate on during the calibration process.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Influenza

Plausible alternative diagnoses:

- Meningitis
- Sepsis from another cause; for example, atypical pneumonia, urinary tract infection
- Malaria

Clinical Communication Skills (Clinical Skill C)

- Obtains history of abrupt onset of classic influenzal symptoms

Managing Patients' Concerns (Clinical Skill F)

- Explains the necessary investigations
- Explains carefully the likely diagnosis
- Issues reassurance about treatment and outcome

Clinical Judgement (Clinical Skill E)

- Discusses management and appropriate investigations to include blood tests i.e. full blood count, serum C-reactive protein, urea and electrolytes, liver function tests, blood cultures, thick and thin films; as well as urinalysis and chest X-ray
- Considers whether or not lumbar puncture is really necessary; willing to seek senior advice
- Administers paracetamol or similar, considers fluid balance
- Allows home if satisfied it is not meningitis or sepsis of other cause

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

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